Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALLIED MEDICAL CENTER

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-11-0585-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 18, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule sates that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. The denial code and their description are too vague for our facility to determine the basis for the denial. This denial is not in compliance with Rule § 133.3."

Amount in Dispute: $400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Chartis did reimburse $193.84 of the $800.00 billed for this date of service. The reduction was due, per the attached EOB, to the DWC fee schedule of $347.60, then a further reduction per a PPO contract with Aetna, resulting in the $193.84 payment."

Response Submitted By: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2009	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$400.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
3. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charge exceeds your contracted/legislated fee arrangement.
   - W1-Workers Compensation State Fee Schedule Adjustment.
   - X394-Our position remains the same if you disagree with our decision please contact the TWCC Medical

Dispute Resolution.

- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on December 9, 2009?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On December 6, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

   28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

   The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §134.204 (g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

   A review of the submitted Functional Capacity Evaluation report indicates "Evaluation Time: 9:00-1:00pm (w/data review & report)."

   The Division finds that the Functional Capacity Evaluation report noted the four hours that were billed by the requestor; however, it does not comply with the billing requirements for CPT code 97750 because it did not indicate the amount of time that was actually spent testing. Furthermore, the requestor noted that evaluation time included "(w/date review & report)" that are services not related to direct one-on one time. Therefore, the Division concludes that the requestor has not supported billing the four hours of service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/10/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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